AUTISM FORUM

April 29 2015 - 8:30 pm to 4:00 pm

Presented by:

DIAGNOSTIC CENTER CENTRAL CALIFORNIA
FOCUS ON UNITY and CENTRAL VALLEY CAPTAIN CADRE

New Dimensions: Emotional and Behavioral Disorders and Autism

- Amanda Aspen, M.A., Education Specialist, Diagnostic Center, Central CA

In the News

- Lisa Stack, Special Education Consultant, BCBA
  Fresno County office of Education and Central Valley CAPTAIN Cadre Co-Leader
- Farah McGovern, School Psychologist, BCBA
  Fresno County Office of Education and Central Valley CAPTAIN Cadre Co-Leader

MORNING		AFTERNOON	
8:30	Welcome and Introductions	1:15	Raffle
8:45	In the News	1:20	In the News
9:00	New Dimensions	1:30	New Dimensions
10:15	Break	2:30	Break
10:30	In the News	2:45	In the News
10:40	New Dimensions	2:55	New Dimensions
11:45	Lunch	3:45	Wrap Up & Evaluations

- Coffee and Tea provided in the morning
- Lunch will be on your own-restaurant map of downtown Clovis provided
- Raffle after lunch--must be present to win

- CAPTAIN T-Shirts available for purchase
- SLP CEUs provided (information provided on your Certificate of attendance)
- PowerPoint available for download at www.dcc-cde.ca.gov

IN THE NEWS

www.inthenews.com AUTISM FORUM NEWSPAPER - Since ???

CHARGE!

IN THE NEWS

www.inthenews.com AUTISM FORUM NEWSPAPER - Since ???

Environmental Pollutants!

IN THE NEWS

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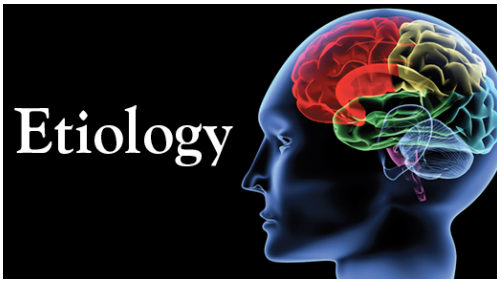
Health Concerns!

Autism Forum

Ananda Aspen



‘cause or origin’

Autism Spectrum Disorders

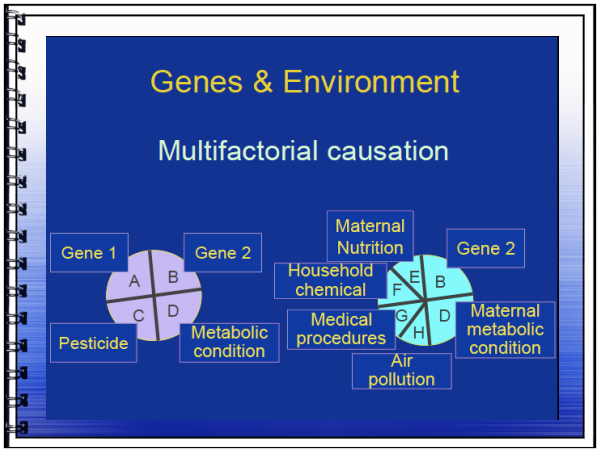
Most of the data presented is correlational (not causal or ‘due to’)

New dimensions in etiology

better understanding of ‘risk variables’

- maternal health
- genetics
- environmental factors

It is time to give up on a single explanation for autism.



Irva Hertz-Picciotto. (August, 2013). Current state of the science on environmental factors in autism. Davis, CA: Summer Institute.

Genetic factors

congenital

epigenetic

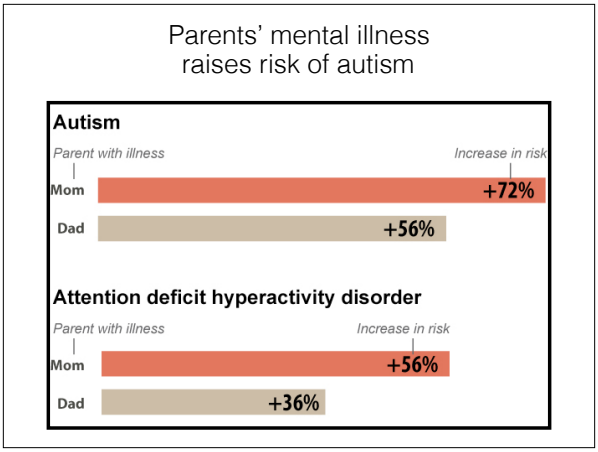
de novo

A gene variant that puts a family at risk could lie dormant for generations. But once a mutation occurs on top of that variant, known in genetics as “de novo” mutation (Latin for “from the beginning”), that variant goes live and autism expresses.

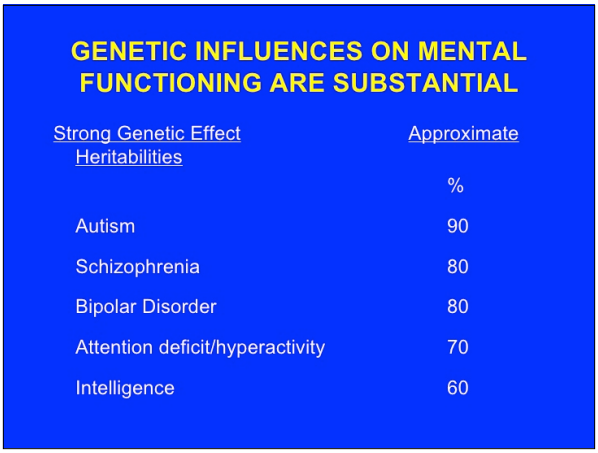
epigenetic risk factor in ASD

Studies show that phenotype and epigenetic marks can be modified by factors such as maternal diet, pharmaceuticals, smoking, and metals and behavior.

for more information, watch this video: http://media.mindinstitute.org/video/epigenetics/fallin_epigenetics_2013_web.mov



From a study published 23 May, 2014 in Annals of Epidemiology



From Michael Rutter, 2015

The best way to think through this is to consider a simpler outcome — "height." Roughly 80 percent of the factors that determine how tall we'll be come from the information written into our DNA. The other 20 percent come from the environment. And yet, every generation gets taller, and mostly as the result of diet. Height appears to

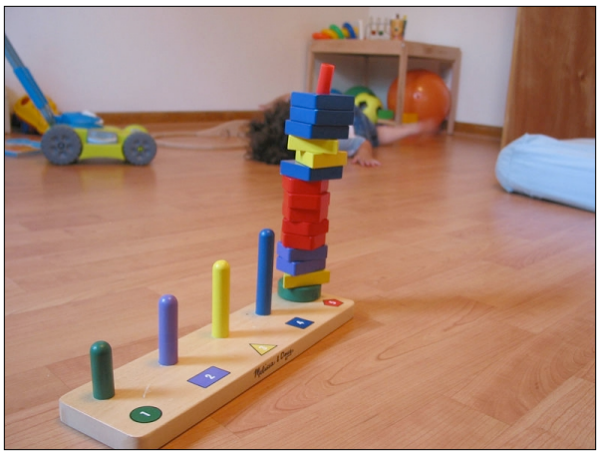
Reduce risk through eliminating variables that contribute to a higher risk factor.
Irva Hertz-Picciotto. (August, 2013). Current state of the science on environmental factors in autism. Davis, CA: Summer Institute.

future

Future research may focus on developing a genetic “score” that families could use to determine their offspring’s risk for autism.

This score would take into account the various small, but compounding effects of each gene variant and use them to complement healthy environmental choices, such as diet and exposure to pollutants.

Source: Gaugler T, Klei L, Sanders S, et al. Most genetic risk for autism resides with common variation. Nature Genetics. 2014.



Multiple individual risk factors lead to autism, including genetic factors, de novo mutations, drug and environmental exposures, maternal infections during pregnancy, selenoenzymes and antioxidant metabolism, maternal nutrients and supplement deficiencies, or abnormalities in the gut flora

Neuroinflammation is a risk factor associated with the environmental teratogens mentioned by Liza, Farah, and Ananda, reporting on recent research in the etiology of ASD.
In addition, new research indicates there may be ongoing/prolonged neuroinflammation processes in the developing child that are intricately

nature vs. nurture

Etiology

'cause or origin'
emotional and behavioral disorders

We use the language "risk factors" and "associated with" rather than "causes" and "due to" because at this point, much of the data is still correlational - but such risk factors are still considered significant and real enough that clinicians and IEP teams should flag them.

Suspected Etiologies of Emotional or Behavioral Disorders

Biological risk factors

- Genetic influences in families: autism, bipolar disorder, schizophrenia, obsessive-compulsive disorder, Tourette's syndrome, depression
- Biological influences: infection, lead poisoning, toxin exposure, prenatal cocaine or alcohol exposure

Psychosocial (environmental) risk factors

- Parental discord, poverty, neglect, abuse, rejection, poor health care, poor nutrition

high association with premature birth (even with late preterm births)

high association with other disorders related to immune deficiency (asthma, allergies)

high association with impaired resiliency to perceived threats and disappointments

Complex trauma that occurs during development

can impact the child's cognition, health, and interpersonal skills

might be a form of PTSD through chronic serial trauma exposure

can be at the root of an emotional and behavioral disorder

"Risk Factors" for EBD

Nature plus Nurture

- Parenting influence
- Genetic transmission of personality and behavioral characteristics
- Cycles of poverty/drug abuse/poor nutrition/ community violence and much more…
- Probably not one pathway that leads to EBD

Top 5?

- Community Violence
- Complex PTSD Trauma
- Domestic Violence
- Early Childhood Trauma
- Medical Trauma
- Natural Disasters
- Neglect
- Physical Abuse
- Refugee and War Zone Trauma
- School Violence
- Sexual Abuse
- Terrorism
- Traumatic Grief

Other Risk Factors

Children born prematurely are four times more likely to have a behavioral disorder.

- Boys born prematurely showed a higher degree of externalizing behavior and ADHD and girls tend to experience more internalizing disorders such as anxiety and depression.

New associations with TBIs that occur during early childhood, language deprivation, and maternal nutritional deficiencies during pregnancy

Nauert, R. (2008). Premature children at risk for behavioral disorders. *Psych Central*.

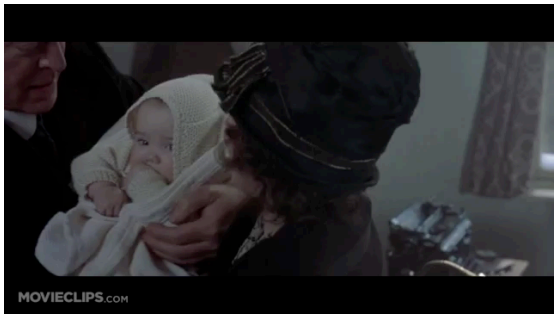
Complex Trauma Disorders

Most traumatic experiences in children and adolescents occur in their immediate social environment.

Families with neglected, maltreated, or abused children often carry a number of additional risk factors, such as mental disorders in parents, poverty, cramped living conditions, or social isolation.

Moreover, childhood traumatization leads to a significantly higher risk of suffering other traumata in adult life.

The behavioral and emotional adaptations that maltreated children make in order to survive are brilliant, creative solutions,and are personally costly.



The Cider House Rules - disorganized attachment resulting from frequent changes in placements in early years.

What about Post Traumatic Stress Disorder?

Many severely maltreated, sexually abused, or neglected children who had suffered repeated traumatic events (i.e., chronic or sequential traumatization) do not fulfill the diagnostic criteria of PTSD in the strict (adult) sense.

Complex Post-traumatic Stress Disorder, also known as "complex trauma", is the result of multiple traumatic events occurring over a period of time, for example caused by multiple incidents of child abuse. Complex Post-traumatic Stress Disorder is a not a diagnosis in the DSM-5, but is proposed to be included in the ICD-11 diagnostic manual, due for release

PTSD types of trauma

PTSD: traumata can be single, well-defined, more public traumata such as accidents, natural disasters, and wartime experiences.

Typical traumatization may produce the classic psychopathological symptoms of PTSD.

Complex PTSD trauma during childhood development

involves a series of related, sequential traumata such as neglect, maltreatment, and sexual abuse often committed secretly and over longer time periods by persons close to the victim.

Sequential traumatization may result in impaired development of personality and heterogeneous psychopathological symptoms.

Developmental Trauma Disorder is a quite well-known term used to refer to Complex PTSD symptoms in children. [11] Like Complex PTSD it is caused by repeated and/or prolonged periods of trauma, for example child abuse by a familiar person. It was not included in the final DSM-5. Read more: http://traumadissociation.com/ptsd

Complex Trauma - *the fallout*

Dissociation, low self-efficacy, impaired regulation of emotion, somatization, and disturbed perception of self and others are all among the symptoms that can be caused by chronic traumatization.

Preschool PTSD

The criteria for Preschool PTSD criteria are "developmentally sensitive". Some of the DSM 5 changes in wording include:

constricted play is an example of "diminished interest in significant activities"

social withdrawal or behavioral changes can indicate "feelings of detachment or estrangement.

extreme temper tantrums are now included with "irritability or outbursts of anger"

intrusive symptoms such as flashbacks and intrusive thoughts do not always manifest overt distress in preschool children

Scheeringa (2014) states that "while distressed reactions are common, parents also commonly reported no affect or what appeared to be excitement". Fewer avoidance symptoms are included because avoidance is internalized, and harder to detect by observation, for example in pre-verbal children. Read more:

close to home

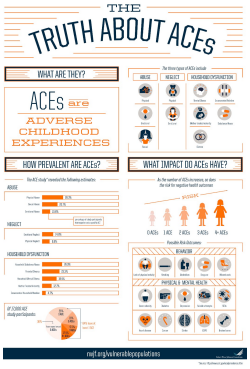
Most traumatic experiences in children and adolescents occur in their immediate social environment.

Families with neglected, maltreated, or abused children often carry a number of additional risk factors, such as mental disorders in parents, poverty, cramped living conditions, or social isolation.

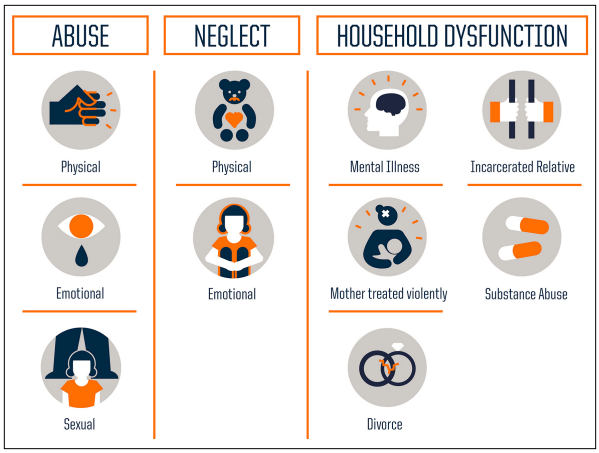
Moreover, childhood traumatization leads to a significantly higher risk of suffering other traumata in adult life.

Adverse Childhood Experience (ACE)

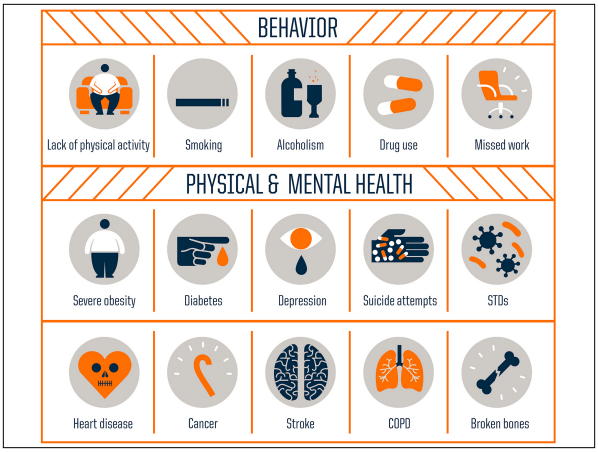
lets take the test based on our own childhood experiences



To learn more, check the CDC's ACE Study website. You'll find, among other things, a list of studies that explore the ways adverse childhood experiences have been linked to a variety of adult conditions, ranging from increased headaches to depression to heart disease. Remember this, ACE scores don't tally



Three types of ACES



ACEs Increase Health Risks

According to the Adverse Childhood Experiences study, the rougher your childhood, the higher your score is likely to be and the higher your risk for various health problems later.

Social and legal aspects

Many victims of neglect, child abuse, and maltreatment live on the edge of society and depend on social services for most of their lives.

Failures at school and in youth welfare institutions are common.

Clear definition of trauma-related symptoms could help to change attitudes towards delinquent or aggressive adolescents and facilitate the initiation of treatment.

and awareness...

Traumatic childhood incidences correlated with an increased likeliness to die prematurely, and that the risk increased with more events. Traumatic incidents can also affect a child's gene expression. A recent study found that people with post-traumatic stress disorder (PTSD) who had gone through an adverse childhood experience

What is an EBD?

An emotional and behavioral disorder(EBD) should be defined as a disability characterized by behavioral or emotional responses in school programs so different from appropriate age, cultural, or ethnic norm that the responses adversely affect educational performance, including academic, social, vocational, and personal skills.

From: National Mental Health and Special Education Coalition

What causes an EBD?

- Several different factors or a combination of them put a child at high risk for the development of an Emotional or Behavioral Disorder that is related to disruptions in forming attachments.
- Critical period is from conception to twenty six months of age
  - Frequent moves or placements (foster care, failed adoptions)
  - Sudden separation from primary caregiver
  - Abuse (physical, emotional, sexual)

Deprivation, deprivation, deprivation

The origin of some EBDs

- Traumatic prenatal experience (drug exposure, etc.)
- Maternal ambivalence toward pregnancy and infant
- Neglect
- Undiagnosed and/or painful illness (ear infections)
- Inconsistent day care
- Unprepared mothers with poor parenting skills
- Birth trauma

Pathogenic care may take many forms, and those listed above may not be considered during the screening process. It is wise to look beyond the clinical terminology to investigate factors that may contribute to the student's neurobehavioral profile.

Prenatal exposure

We assume that many drugs and other substances (both legal and illegal) may interfere with normal embryonic development.

Fetal Alcohol Spectrum Disorders (FASD)

an umbrella term intended to encompass all individuals along a broad continuum of clinical deficits related to prenatal alcohol exposure

Prenatal Cocaine Exposure (PCE)

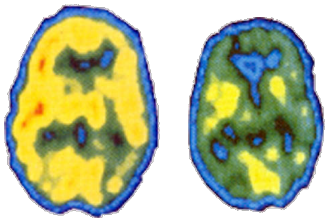
Neurodevelopmental disorder associated with prenatal cocaine exposure

and chronic early life trauma"

Brain development

Prenatal to the first 2 years of life and the quality of care-taking impacts brain development

- alarm reactions alter
- chemical wiring
- traumatized infants and children
- neurobehavioral problems



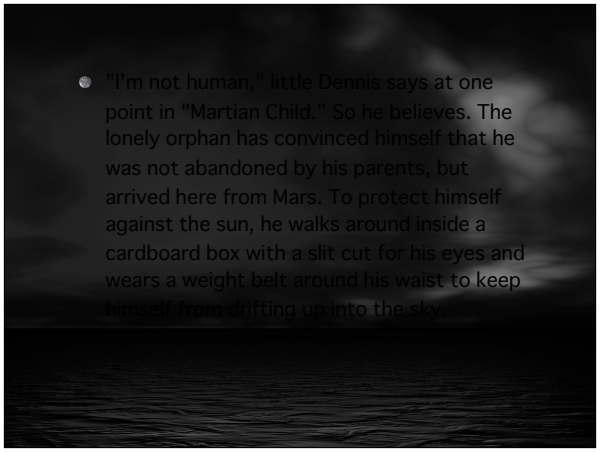
What is attachment?

- Bond between primary caregiver and child
- Develops in first year of life
- Basis for all other relationships

Disruptions in attachment that occur before the child develops language can result in an attachment disorder in some children.

Why is attachment important?

- Essential foundation for healthy personality and functioning in society
  - Influences:
    - Cognitive ability
    - Development of conscience
    - Coping skills (frustration and stress)
    - Relationship development
    - Ability to handle perceived threats
    - Ability to handle negative emotions

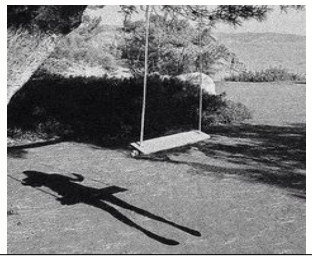


David Gordon (John Cusack), a popular science fiction author, was widowed when his wife Mary died as they were trying to adopt a child. Two years later, David is finally matched with a young boy named Dennis. Socially awkward, Dennis believes he is from Mars and only goes outdoors when under the cover of a large box to

IN THE NEWS

www.inthenews.com AUTISM FORUM NEWSPAPER - Since ???

Hiding in Plain Sight!



IN THE NEWS

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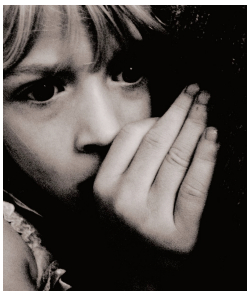
Lost and Found!

Characteristics

of Emotional Behavioral Disorders

So What is Reactive Attachment Disorder?

- RAD is not simply insecure attachment patterns
- RAD is pathogenic care combined with genetic and environmental influences that produces significant impact on the brain and body



What about explosive toddlers and preschoolers?

The diagnosis should not be made before the age of 6 or after 18.

Disruptive Mood Dysregulation Disorder

Newly described mental health disorder in children

chronic, severe persistent irritability in children and adolescents

low frustration tolerance and exhibit difficulties with emotional regulation, distress tolerance, and behavioral self-control

the prevalence of disruptive mood dysregulation disorder among children and adolescents is estimated to fall into the 2%–5% range

In order to meet the diagnostic criteria for DMDD, children must demonstrate outbursts at least three times per week for a period of at least one year across at least two of the following settings: home, school, and with peers (APA 2013). Children who meet the criteria for DMDD will often present as irritable and angry throughout the day.

DSM V criteria for RAD

A) A pattern of markedly disturbed and developmentally inappropriate attachment behaviors, evident before 5 years of age, in which the child rarely or minimally turns preferentially to a discriminated attachment figure for comfort, support, protection and nurturance. The disorder appears as a consistent pattern of inhibited, emotionally withdrawn behavior in which the child rarely or minimally directs attachment behaviors towards any adult caregivers, as manifest by both of the following:

Rarely or minimally seeks comfort when distressed.

Rarely or minimally responds to comfort offered when distressed.

pick two

B. A persistent social and emotional disturbance characterized by at least 2 of the following:

1) Relative lack of social and emotional responsiveness to others.

2) Limited positive affect.

3) Episodes of unexplained irritability, sadness, or fearfulness which are evident during nonthreatening interactions with adult caregivers.

C. Does not meet the criteria for Autistic Spectrum Disorder.

at least one

D. Pathogenic care as evidenced by at least one of the following:

1) Persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection (i.e., neglect).

2) Persistent disregard of the child's basic physical needs.

3) Repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care).

4) Rearing in unusual settings such as institutions with high child/caregiver ratios that limit opportunities to form selective attachments.

E. There is a presumption that the care in Criterion D is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion D).

F. The child has a developmental age of at least 9 months.

Disinhibited Social Engagement Disorder

DSED - is a new diagnostic category, DSED includes types of disorder of attachment in which children are socially disinhibited - infants and children who are not cautious with strangers and will go to most anyone. If the child has no apprehension about strangers or who shows indiscriminate sexual behavior, they may be at risk for DSED.

DSM V Criteria: A. A pattern of behavior in which the child actively approaches and interacts with unfamiliar adults by exhibiting at least 2 of the following:

1) Reduced or absent reticence to approach and interact with unfamiliar adults.
2) Overly familiar behavior (verbal or

DSED

Kids described with DSED are prone to social and verbal intrusiveness and attention-seeking behavior during childhood, and superficial peer relationships along with enhanced peer conflicts during adolescence.

Kids with DSED are more likely to be confused with kids with ADHD, while kids with RAD are more likely to be confused with kids with autism. Lack of capacity for self-regulation in social situations is a key feature of DSED, while a lack of comfort-seeking behavior is characteristic of RAD.

Interesting study

DSED appears not to be responsive (or only minimally responsive) to enhanced caregiving, whereas RAD is often very responsive. One study done in Romania comparing foster care to institutionalized care found a significant reduction in signs of RAD among children placed in foster care, but no reduction in the signs of DSED.

Smyke, A. T., Zeanah, C. H., Fox, N. A., Nelson, C. A., & Guthrie, D. (2010). Placement in Foster Care Enhances Quality of Attachment Among Young Institutionalized Children. Child Development, 81(1), 212–223. http://doi.org/10.1111/j.1467-8624.2009.01390.x

What causes RAD/DSED?

- Several different factors or a combination of them put a child at high risk for the development of RAD
- Critical period is from conception to twenty six months of age
  - Frequent moves or placements (foster care, failed adoptions)
  - Sudden separation from primary caregiver
  - Abuse (physical, emotional, sexual)

Deprivation, deprivation, deprivation

What causes RAD/DSED?

- Traumatic prenatal experience (drug exposure, etc.)
- Maternal ambivalence toward pregnancy and infant
- Neglect
- Undiagnosed and/or painful illness (ear infections)
- Inconsistent day care
- Unprepared mothers with poor parenting skills
- Birth trauma

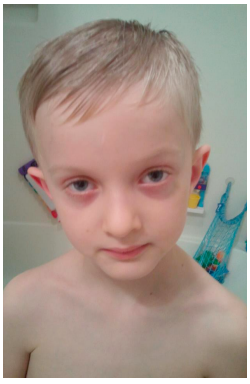
High Risk Signs in Infants

- Weak crying response
- Extreme resistance to cuddling
- Poor sucking response
- No reciprocal smile response
- Failure to respond with recognition to primary caregiver
- Delay in developmental milestones

High risk signs in children

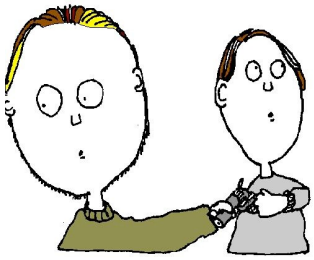
- Superficially engaging and charming
- Indiscriminately affectionate
- Destruction of self, others, or things
- Developmental lags
- No eye contact
- Cruel to animals or siblings
- Poor peer relationships
- Inappropriately demanding and clingy

- Stealing and lying
- No conscience
- Poor impulse control
- Persistent nonsense questions
- Hoarding or gorging on food
- Preoccupation with fire, blood, or gore
- Abnormal speech patterns
- Somatic complaints
- Poor immune system
- Manipulation/triangulation patterns



fuzzy dies

What RAD looks like



What gun? I don't see a gun

Can look like other disorders

- RAD can look like ***Oppositional Defiant Disorder*** or ***Conduct Disorder***
- Characterized by many of the same behaviors
- Children may exhibit characteristics similar to ***ADHD***
- However, RAD is characterized by *early disruptions in attachment*
  - This is the distinguishing feature

unqualified clinicians may inadvertently diagnosis other disorders that have different therapeutic recommendations - may not be conducive to healthy recovery in RAD kids

Characteristics of RAD in Children- from RadKids.org

- **Superficially charming and engaging, particularly around strangers or those who they feel they can manipulate**
- **Indiscriminate affection, often to strangers; but not affectionate on parent's terms**
- **Problems making eye contact, except when angry or lying**
- **A severe need to control everything and everyone; worsens as the child gets older**
- **Hypervigilant**
- **Hyperactive, yet lazy in performing tasks**
- **Argumentative, often over silly or insignificant things**
- **Frequent tantrums or rage, often over trivial issues**
- **Demanding or clingy, often at inappropriate times**
- **Trouble understanding cause and effect**
- **Poor impulse control**
- **Lacks morals, values, and spiritual faith**
- **Little or no empathy; often have not developed a conscience**
- **Cruelty to animals**

Non clinical description - but accurate!

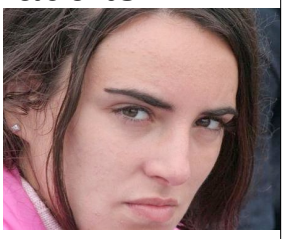
Child sex abuse may lead to PTSD, Reactive Attachment Disorder, sex trafficking
Read the story of Brandi, a case study of a 16 year old girl. http://www.examiner.com/article/child-sex-abuse-may-lead-to-ptsd-reactive-attachment-disorder-sex-trafficking

Characteristics of RAD in Adults – from RadKids.org

- **Unreasonable or inappropriate anger**
- **Hostile**
- **Overcritical of others and self**
- **Intolerant of rules and authority**
- **Lack of empathy or remorse**
- **Views others as untrustworthy and unreliable**
- **Shallow/Vain**
- **Feelings of self-importance**
- **Feelings of entitlement or arrogance**
- **Self-reliance; prefers to work alone than with others**
- **Views relationships as threatening, or not worth the effort**
- **May be a workaholic, as a way of avoiding relationships**
- **Feelings of being unique**
- **Grandiose or unrealistic fantasies**

Do you know anyone with these characteristics?

More on adults



May Also Include

- **Prone to depression**
- **Socially inappropriate behavior**
- **Impulsive**
- **Manipulative**
- **Risk-taking**
- **Self-mutilating behavior**
- **Often do not remember much of childhood experiences**
- **Darkness behind the eyes when angered**
- **At risk of abusing their own children**
- **Children with RAD may become adults diagnosed with sociopathic, narcissistic, antisocial, or borderline disorder**

again - not a clinical description - but accurate!

What about alternative family placement for children with RAD?

- Placement is tough and often times disrupted
- Disrupted placements further exacerbate the issue
- RAD has an impact on the family that can't be ignored
- Training is important for these adoptive or foster families

COPING

Triangulation patterns

Triangulation (setting one adult against another through deception and manipulation)

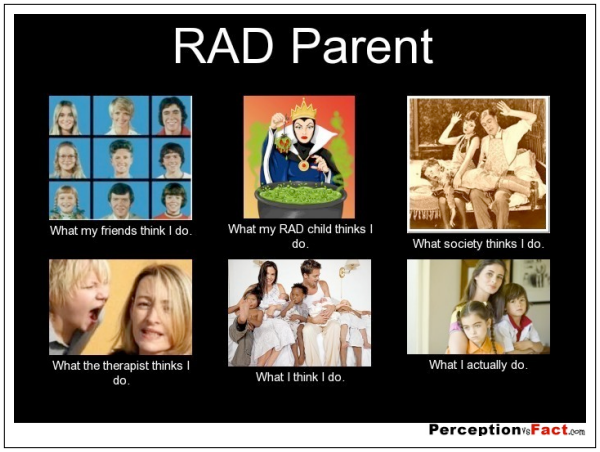
key feature that interventionists need to understand

Impact on Family

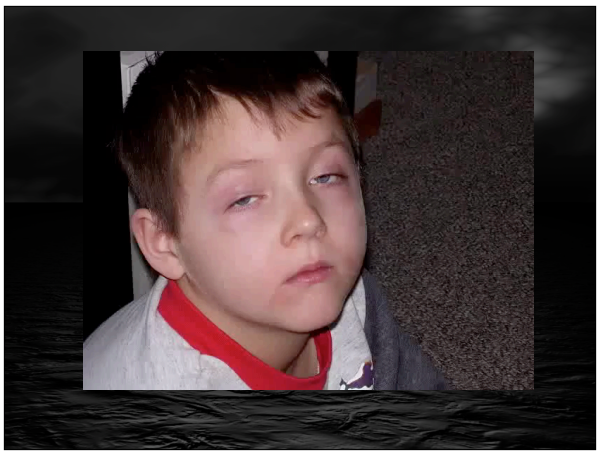
- Dreams of solving all the problems with love nurturing can be quickly squashed
- Parents become frustrated as they try to receive reciprocal love
- School and other family members can become critical of family

Impact on Family

- Siblings may be threatened and targeted
- Family pets may be targeted
- Family becomes controlled by the child, serving to withdraw them from normal social functions
- 'Automatic' parenting won't work
  - no logic to how to deal with behavior



from the internet



Can you form attachments with these children?

- Yes, with time and time and more time
- How:
  - Eye contact
  - Touch
  - Smile
  - Parenting encourages reciprocity on parent's terms
  - Working together in reciprocal way
  - Demonstrate affection regardless of response

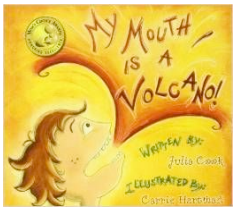
Educational considerations

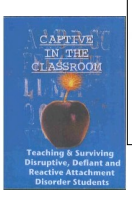
- Do not push away when behaviors become challenging
  - As time goes by, expressing emotions, such as anger, jealousy, and neediness, becomes safe
  - Security enhances self-regulation and ability to begin developing sustainable attachments
  - Resiliency can develop at any age
    - Health
    - Emotional

psychological safety…

How do we promote this?

RAD/teaching issues





My Mouth is a Volcano - This is an incredible book to promote a child's self-awareness about verbally raging and blurting out rude comments. The story is engaging, the artwork is quirky, and children seem to gain insight into ways to choose their words more carefully!!! We have used this book to promote social behavior and manners

use science!

More….

- Be strong and consistent!
- No control battles
- Listening actively to behavior (encourage feelings expression)
- Do not allow triangulation
- Don't become emotional
- Schedules and consistency are key
- Make sure your principal, school psychologist, and other support staff know of your concerns and have information on RAD

- These parents often times need a respite
  - Be a partner, not an adversary in the struggle to support the child with RAD
  - Support the parents (thus you will be supporting the child)

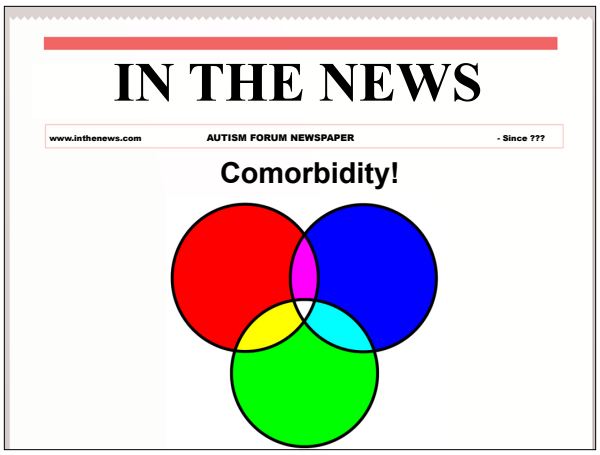
therapy

- Inclusive – family is together during sessions
  - Discourages triangulation
  - Enhances security
    - parents care and are getting child help
    - Therapist can be neutral buffer
    - reinforces family bonds

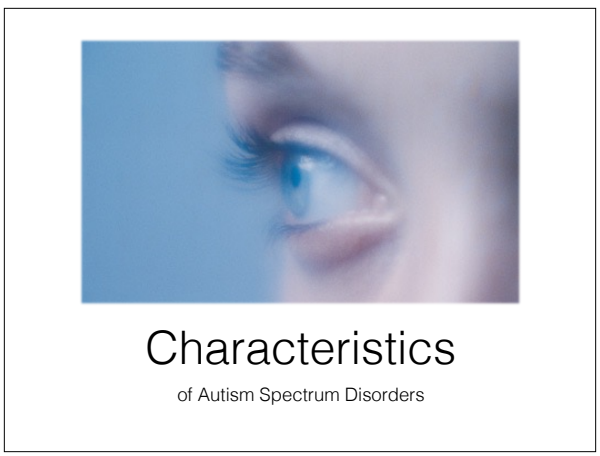
There should always be hope

And optimism!


IN THE NEWS
www.inthenews.com
AUTISM FORUM NEWSPAPER
- Since ???
Bridging Gaps in Mental Health!
Mental health
disorders
undetected
Psychiatr
for more fac


IN THE NEWS
www.inthenews.com
AUTISM FORUM NEWSPAPER
- Since ???
Comorbidity!


CAPTAIN
Central Valley CAPTAIN
Public Group · 176 Members
Joined
Add Members
Search
Info
Autism Forum "New Dimensions: Emotional and Behavioral Disorders and Autism"
Today, 8:30 AM - 4:00 PM


Characteristics
of Autism Spectrum Disorders

diagnostic median age is 4

many higher functioning children do not get diagnosed until later…

characteristics are still difficult for many to identify in young children

---

Lorna Wing found in her paper on sex ratios in early childhood autism that among people with 'high-functioning autism' or Asperger syndrome there were as many as 15 times as many men and boys as women and girls, while in people with learning difficulties as well as autism the ratio of men and boys to women and girls was closer to 2:1.

This could suggest that, while women and girls are less likely to develop autism, when they do they are more severely impaired. Alternatively, it could suggest 'high-functioning' women and girls with autism have been underdiagnosed, compared to men and boys.

The current international diagnostic criteria for autism (in ICD-10) and the DSM 5 do not give examples of the types of difficulties experienced by women and girls.

In order to recognize the different behaviors, it is important to take a much wider perspective regarding the social, communication and imagination dimensions in addition to the special interests and rigidity of behavior.

Women and girls learn to act in social settings. Unenlightened diagnosticians perceive someone who appears able, who has reciprocal conversation and who uses appropriate affect and gestures as not fulfilling the criteria set out in the international classification systems. Therefore a diagnosis is missed.

Females with ASD

- **Social interaction**
  - **greater awareness of the need for social interaction**
  - **desire to interact with others**
  - **passivity (a "loner", often perceived as "just being shy")**
  - **Tendency to imitate others (copy, mimic, or mask) in social interactions, which may be exhausting Tendency to "camouflage" difficulties by masking and/or developing compensatory strategies**
  - **One or few close friendships**
  - **Tendency to be "mothered" in a peer group in primary school but often bullied in secondary school**

from Journal of Adolescent Psychiatry, January 2015.

females…

- **Communication**
  - **Better linguistic abilities developmentally**
  - **Better imagination (fantasizes and escapes into fiction and pretend play, but is prone to being nonreciprocal, scripted, and overly controlled).**
- **Restricted repetitive patterns of behavior, interests, or activities**
  - **Restricted interests tend to involve people/animals rather than objects/things (e.g., animals, soap operas, celerities, pop music, fashion, horses, pets, and literature), which may be less recognized as related to autism.**

- **Other**
  - **Tendency to be perfectionistic, very determined**
  - **Tendency to be controlling (in play with peers)**
  - **High (passive) demand avoidance**
  - **Tendency to have episodes of eating problems**

New dimensions in definitions

Social Communication

Restricted and Repetitive Behaviors

Insistence on Sameness

Spectrum of severity and need for supports

Amendments to State Regulations on Autism Eligibility
California Code of Regulations
5 CCR § 3030. Eligibility Criteria.

Prior to July 1, 2014	July 1, 2014
3030 (g) A pupil exhibits any combination of the following autistic-like behaviors, to include but not limited to:	(1) Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, and adversely affecting a child's educational performance. Other **characteristics often associated** with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.
(1) An inability to use oral language for appropriate communication.	
(2) A history of extreme withdrawal or relating to people inappropriately and continued impairment in social interaction from infancy through early childhood.	
(3) An obsession to maintain sameness.	
(4) Extreme preoccupation with objects or inappropriate use of objects, or both.	
(5) Extreme resistance to controls.	
(6) Displays peculiar motoric mannerisms and motility patterns.	
(7) Self-stimulating, ritualistic behavior.	
	(A) Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in subdivision (b)(4) of this section.
	(B) A child who manifests the characteristics of autism after age three could be identified as having autism if the criteria in subdivision (b)(1) of this section are satisfied.

CA Ed Code

Amendments to State Regulations on Autism Eligibility

The new CA Code of Regulations: deletes the term "autistic-like behaviors"

–adds the term "characteristics

For an individual to be deemed to possibly have Autism Spectrum Disorder they must report a score of 2 (*Often*) or 3 (*Very Often*) for all three of the three **Social Communication and Social Interaction** items, and at least two of the four **Restricted, Repetitive Patterns of Behaviour, Interests or Activities** items.

Furthermore, two supplementary *Yes/No* questions pertaining to the caveats provided in DSM-5 must also be met. These questions relate to the length of symptoms, and the adverse affect of the symptoms on the individuals overall functioning.

Results:
Summary of Diagnostic Criteria as per DSM-5:

There are seven DSM-5 criteria for Autism Spectrum Disorder in two domains. To meet the diagnostic criteria for Autism Spectrum Disorder, all three criteria from the Social Communication and Interaction domain (A) and at least two criteria from the Behaviour domain (B) must be met. The difficulties must have been present in the early developmental period; cause clinically significant impairment in social, occupational, or other important area of functioning; and not be better explained by intellectual disability or global developmental delay.

	Social Communication and Interaction		Restricted, Repetitive Patterns of Behaviour
1.	Criterion met [2]	4.	Not met [1]
2.	Criterion met [2]	5.	Criterion met [3]
3.	Criterion met [2]	6.	Criterion met [3]
		7.	Criterion met [3]

(1) Have these behaviours been causing problems since early childhood? Yes

(2) Do these behaviours adversely affect social, academic, and/or occupational functioning? Yes

****

3 Number of Deficits in Social Communication and Social Interaction criterion met.

3 Number of Restricted, Repetitive Patterns of Behaviour, Interests or Activities criterion met.

Using a DSM 5 table in reports [examples from Mirit Friedland and Virginia Salazar's Autism Assessment workshop; Diagnostic Center North]

B. Restricted, Repetitive Patterns of Behaviour, Interests, or Activities, as Manifested by at Least Two of the Following, Currently or by History:

1. Stereotyped or repetitive motor movements, use of objects, or speech.

This criterion will be rated by the Speech Pathologist.

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviour.

Parental report and observation indicated that Jane has significant difficulties in the area of insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviour. Changes in routine can cause distress. Minor changes are tolerated (e.g., breakfast time, what she has to eat etc), however, big changes (e.g., a cancelled appointment, changing what time we're going to shops etc), result in a "major meltdown".

Jane's teacher reported concerns in relation to Jane's constant level of anxiety (e.g., she quickly dissolves into tears and heavy breathing over minor changes in the environment, timetable and people in the room). Jane's teacher also reports Jane's behaviour and speech is quite rigid and inappropriate or ritualistic behaviours are hard to shift (e.g., "From term one we told Jane about our classroom rule that she must first eat her sandwich before anything else in her lunchbox at lunchtime. For the next two weeks or so, Jane repeatedly asked "Do I eat my sandwich first?", before beginning her lunch. Once we realised the pattern, we stopped answering her question and she stopped asking and was able to eat her own lunch. A few weeks later we had a cooking lesson where we made toasted sandwiches for lunch. Jane happily ate the sandwich she had made and then went to open her lunchbox and eat the sandwich her mum had sent her. I stopped her and said "Oh Jane, you don't have to eat your sandwich first today, you ate a sandwich at cooking, you can choose a treat from your lunchbox if you like!". Her eyes immediately filled with tears and she said "Please, I have to eat my sandwich first". She was quite distressed and genuinely felt she couldn't eat anything in her lunchbox until she had the sandwich first.")

This criterion is rated as **met**.

[Mirit Friedland and Virginia Salazar's Autism Assessment workshop; Diagnostic Center North]

Difficulties in making friends

- Mrs Smith reported Jane climbs on others/does not respect personal space. She is physical with others, and has difficulty knowing when to stop.
- When playing with other children she is over eager and tries to force them to do what she wants and it has to be done a certain way. The more she does this the less they want to play which in turn makes her worse.
- Jane is over the top social, she thinks everyone is her friend even if she doesn't know them. Unfortunately her way of socialising is being loud, aggressive speech and horrible faces without meaning to be that way. When actually playing with kids she will play alongside if she's not sure what they're doing, but most of the time she yells and tries to physically force them to do what she wants. Her words are they have to play with her. She will imitate play when with an adult in a structured play setting like therapy. When she is in a situation where there are a lot of kids she will stand and watch. She needs prompting with turn taking, listening to others and sharing.
- School Teacher reported at times Jane displays intimidating behaviours when a student does not play with her, including invading personal space, shouting loudly in their faces and at times chasing or pushing them to try and engage them in play.
- During playtime, she seeks sensory feedback from peers by ramming her bike into others intentionally, and becoming quite pushy with peers even when asked to stop.
- Speech Pathologist reported Jane's voice is often angry and frustrated, but when asked if she is angry she will say no. When shown how to take turns and play with toys she can do this, and when told that other people like to make their own choices she will tolerate it.

[Mirit Friedland and Virginia Salazar's Autism Assessment workshop; Diagnostic Center North]

Additional Specifications to be Included

- With or without accompanying intellectual impairment
- With or without accompanying language impairment
- Associated with a known medical or genetic condition or environmental factor
- Associated with another neurodevelopmental, mental, or behavioral disorder
- With catatonia

DSM 5

Twice Exceptional

113

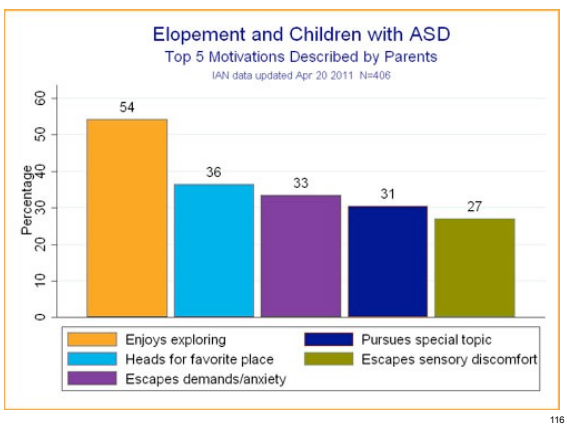
Cam says: I am the "I" in IEP!

Behaviors…

beyond Ed Code and the DSM 5

Nutrition

- Picky eating may create nutritional deficiencies



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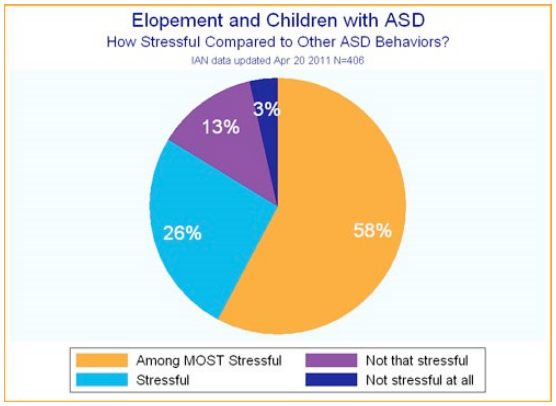

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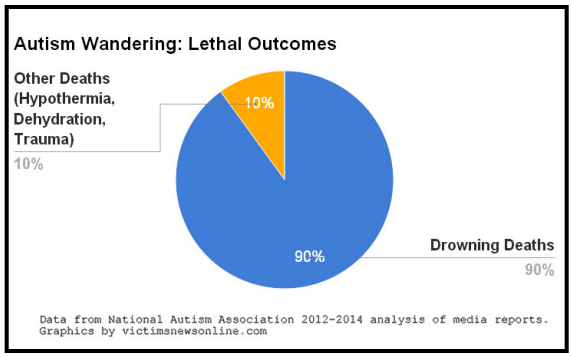
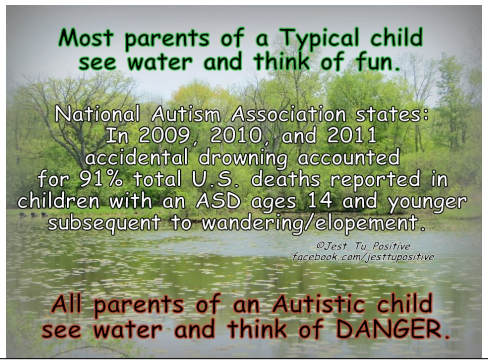


118

The attraction of water



119

Implications

Autism: Educational and community considerations

New EBPs

Cognitive Behavior Therapy

Structured Play Group

Exercise

Program options

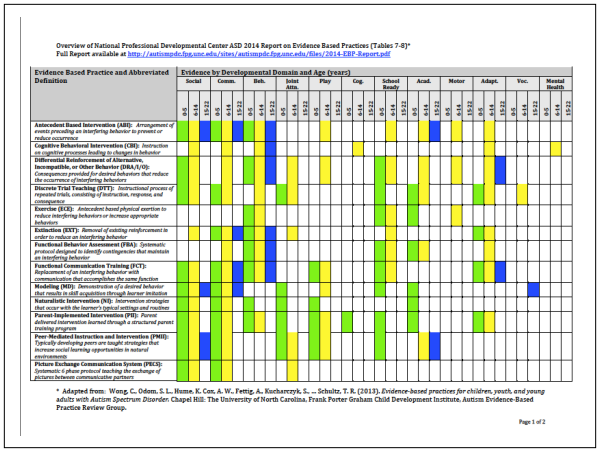
Regional Center Updates

Developmental Center Closures

- Sonoma Developmental Center in 2018 (approx. 390 clients)
- Fairview Development Center to follow (approx. 270 clients)
- Non-secure portions of Porterville in 2021
- Expanded funding for Regional Center service development through Community Placement Plan (CPP)

More Regional Center Updates

- Self Determination Program- 3 year phase in IPPs written in threshold languages within 45 days
  - Threshold= 3000 or 5% Medi-Cal beneficiaries in area
  - Cost neutral change- no additional funding for translation
- Changes to regulations for secure perimeter treatment facilities
- Increase number of enhanced behavior support homes piloted



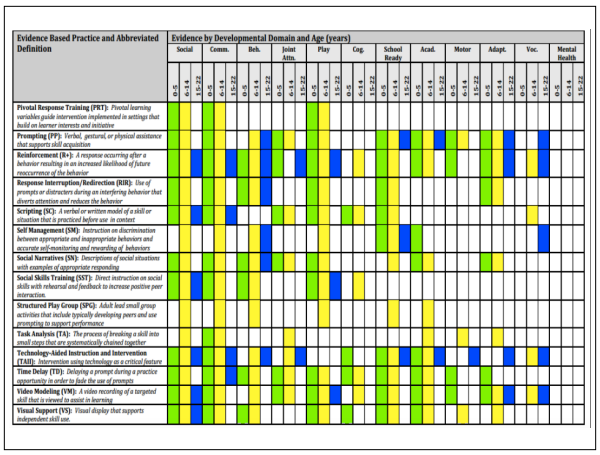
Overview of National Professional Developmental Center ASD 2014 Report on Evidence Based Practices (Tables 7-8)*
Full Report available at http://autismpdc.fpg.unc.edu/sites/autismpdc.fpg.unc.edu/files/2014-EBP-Report.pdf

Evidence Based Practice and Abbreviated Definition	Evidence by Developmental Domain and Age (years)																																	
	Social			Comm.			Beh.			Joint Attn.			Play			Cog.			School Ready			Acad.			Motor			Adapt.			Voc.			Mental Health		
	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22
Antecedent Based Intervention (ABI): *Arrangement of events preceding an interfering behavior to prevent or reduce occurrence*																																				
Cognitive Behavioral Intervention (CBI): *Instruction on cognitive processes leading to changes in behavior*																																				
Differential Reinforcement of Alternative, Incompatible, or Other Behavior (DRA/I/O): *Consequences provided for desired behaviors that reduce the occurrence of interfering behaviors*																																				
Discrete Trial Teaching (DTT): *Instructional process of repeated trials, consisting of instruction, response, and consequence*																																				
Exercise (ECE): *Antecedent based physical exertion to reduce interfering behaviors or increase appropriate behaviors*																																				
Extinction (EXT): *Removal of existing reinforcement in order to reduce an interfering behavior*																																				
Functional Behavior Assessment (FBA): *Systematic protocol designed to identify contingencies that maintain an interfering behavior*																																				
Functional Communication Training (FCT): *Replacement of an interfering behavior with communication that accomplishes the same function*																																				
Modeling (MO): *Demonstration of a desired behavior that results in skill acquisition through learner imitation*																																				
Naturalistic Intervention (NI): *Intervention strategies that occur with the learner's typical settings and routines*																																				
Parent-Implemented Intervention (PII): *Parent delivered intervention learned through a structured parent training program*																																				
Peer-Mediated Instruction and Intervention (PMII): *Typically developing peers are taught strategies that increase social learning opportunities in natural environments*																																				
Picture Exchange Communication System (PECS): *Systematic 6 phase protocol teaching the exchange of pictures between communicative partners*																																				

* Adapted from: Wong, C., Odom, S. L., Hume, K. Cox, A. W., Fettig, A., Kucharczyk, S., ... Schultz, T. R. (2013). *Evidence-based practices for children, youth, and young adults with Autism Spectrum Disorder.* Chapel Hill: The University of North Carolina, Frank Porter Graham Child Development Institute, Autism Evidence-Based Practice Review Group.

Page 1 of 2

find the English and Spanish EBP sheets on the CAPTAIN website under resources.



Evidence Based Practice and Abbreviated Definition	Evidence by Developmental Domain and Age (years)																																	
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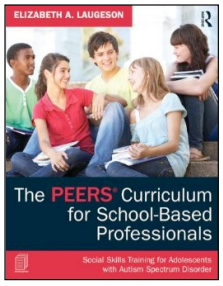
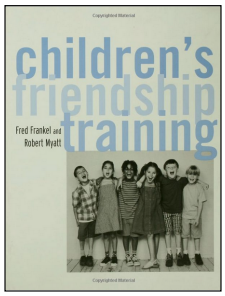
	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22	0-5	6-14	15-22
Pivotal Response Training (PRT): *Pivotal learning variables guide intervention implemented in settings that build on learner interests and initiative*																																				
Prompting (PP): *Verbal, gestural, or physical assistance that supports skill acquisition*																																				
Reinforcement (R+): *A response occurring after a behavior resulting in an increased likelihood of future reoccurrence of the behavior*																																				
Response Interruption/Redirection (RIR): *Use of prompts or distracters during an interfering behavior that diverts attention and reduces the behavior*																																				
Scripting (SC): *A verbal or written model of a skill or situation that is practiced before use in context*																																				
Self Management (SM): *Instruction on discrimination between appropriate and inappropriate behaviors and accurate self-monitoring and rewarding of behaviors*																																				
Social Narratives (SN): *Descriptions of social situations with examples of appropriate responding*																																				
Social Skills Training (SST): *Direct instruction on social skills with rehearsal and feedback to increase positive peer interaction.*																																				
Structured Play Group (SPG): *Adult led small group activities that include typically developing peers and use prompting to support performance*																																				
Task Analysis (TA): *The process of breaking a skill into small steps that are systematically chained together*																																				
Technology-Aided Instruction and Intervention (TAII): *Intervention using technology as a critical feature*																																				
Time Delay (TD): *Delaying a prompt during a practice opportunity in order to fade the use of prompts*																																				
Video Modeling (VM): *A video recording of a targeted skill that is viewed to assist in learning*																																				
Visual Support (VS): *Visual display that supports independent skill use*																																				

Only two social skill training curriculums are evidence-based: PEERS and Children's Friendship Training

For more information - find out who your CAPTAIN cadre members are on the CAPTAIN website: www.CAPTAIN.ca.gov

Social Skills Training





127

Cognitive behavioral intervention (CBI)

is based on the belief that behavior is mediated by cognitive processes.

Learners are taught to examine their own thoughts and emotions, recognize when negative thoughts and emotions are escalating in intensity, and then use strategies to change their thinking and behavior.

These interventions tend to be used with learners who display problem behavior related to specific emotions or feelings, such as anger or anxiety.

Cognitive behavioral interventions are often used in conjunction with other evidence-based practices including social narratives, reinforcement, and parent-implemented intervention.

National Standards Project Phase 2

- The combined results of NSP1 and NSP2 include data from more than 1,000 studies.
- This is the largest review of its kind for individuals with ASD.

Established Interventions

- Behavioral Intervention
- Cognitive Behavioral Intervention Package
- Comprehensive Behavioral Treatment for Young Children
- Language Training (Production)
- Modeling
- Natural Teaching Strategies
- Parent Training
- Peer Training Package
- Pivotal Response Training
- Schedules
- Scripting
- Self-management
- Social Skills Package
- Story-based Intervention

14 interventions

Emerging Interventions

- Augmentative and Alternative Communication Devices
- Developmental Relationship-based Treatment
- Exercise
- Exposure Package
- Functional Communication Training
- Imitation-based Intervention
- Initiation Training
- Language Training (Production & Understanding)
- Massage Therapy
- Multi-component Package
- Music Therapy
- Picture Exchange Communication System
- Reductive Package
- Sign Instruction
- Social Communication Intervention
- Structured Teaching
- Technology-based Intervention
- Theory of Mind Training

18 Interventions

NSP2 Recommendations For Intervention Selection EMERGING INTERVENTIONS

- "We generally do not recommend beginning with these interventions However, Emerging Interventions should be considered promising and warrant serious consideration if Established Interventions are deemed inappropriate by the decision-making team, or were unsuccessful in producing positive outcomes"

Non-Established Interventions

- Animal-assisted Therapy
- Auditory Integration Training
- Concept Mapping
- DIR/Floor Time
- Facilitated Communication
- Gluten-free/Casein-free diet
- Movement-based Intervention
- SENSE Theatre Intervention
- Sensory Intervention Package
- Shock Therapy
- Social Behavioral Learning Strategy
- Social Cognition Intervention
- Social Thinking Intervention

…for which there is no empirical research (NSP2 press release).

13+ Interventions (if interventions have no peer-reviewed research, then by default they belong in this category of non-established interventions).

- Unestablished Interventions either have no research support or the research that has been conducted does not allow us to draw firm conclusions about intervention effectiveness for individuals with ASD. When this is the case, decision-makers simply do not know if this intervention is effective, ineffective, or harmful because researchers have not conducted any or enough high-quality research. *Given how little is known about these interventions, we would recommend considering these interventions only after additional research has been conducted and this research reveals favorable outcomes for individuals with ASD.*

NSP2 exact wording (highlights are Ananda's

Medi-Cal

DHCS
JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 3, 2015

ALL PLAN LETTER 15-025
(SUPERSEDES ALL PLAN LETTER 14-011)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: RESPONSIBILITIES FOR BEHAVIORAL HEALTH TREATMENT COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) about requirements pertaining to the provision of Behavioral Health Treatment (BHT) services to Medi-Cal beneficiaries under 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

BHT services must be provided, observed and directed under an approved behavioral treatment plan. The 14 BHT services that have been identified as evidence-based are described in Phase 2 of the National Standards Project.[6]

CAPTAIN Website

www.captain.ca.gov

You can easily access all these EBPs, NPDC tools and EBP Resources through the CAPTAIN website!

CAPTAIN

Implications

Educational success and social-emotional health

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manipulation

do not allow triangulation
enhance safety and security
do not display weakness

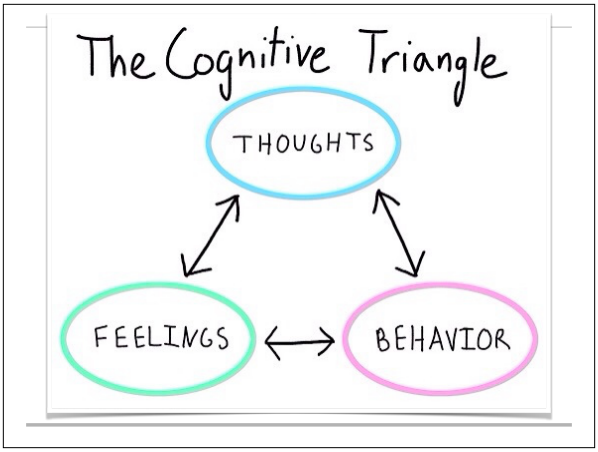
reinforce resiliency and success rather than charm or threats

Mary Agnes - profile of DSED

---

restitution

brings the perpetuator and the victim together
focus on relationships



CBI is based on the theory a thought or idea must precede a mood, meaning there must be something that a person thinks that leads them to feel a certain way. This, in turn, will lead to the way in which people act. It also says that

KEY PROCESSES IN PREVENTION AND INTERVENTION

- Build relationships (student, family, school staff, other)
- Reduce or build boundaries to stress and risk
- Build protective factors
- Educate in key cognitive behavioral skills
- Use evidence-based practices
- Emphasize strong outcome evaluation and continuous program improvement.
- Advocate for program improvement and growth

Teach social-emotional skills

That are:

ecologically sound

relevant

naturally reinforcing

assess areas of need:

systematic approach

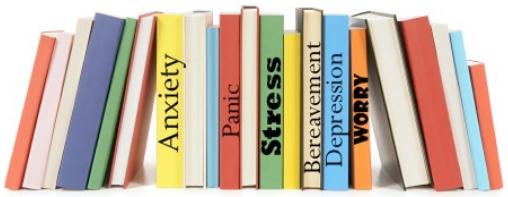
double dip (academics)

Transforming Education, a Boston-based group that is among the biggest proponents of teaching social-emotional skills, argues that they are so important that schools have to begin testing for them, even if perfect measures do not exist. Check out this article for more information: http://www.nytimes.com/2016/03/01/us/

LEARN TO "DOUBLE DIP"
COMBINE ACADEMIC AND SOCIAL EMOTIONAL INSTRUCTION WHEN TEACHING

- Identify critical needs and select readings that have this as the theme.
- Employ instructional strategies that allow students to learn and practice social skills.
- Whenever possible use instructional consequences for behavioral infractions

LEARN TO "DOUBLE DIP"
COMBINE ACADEMIC AND SOCIAL EMOTIONAL INSTRUCTION WHEN TEACHING

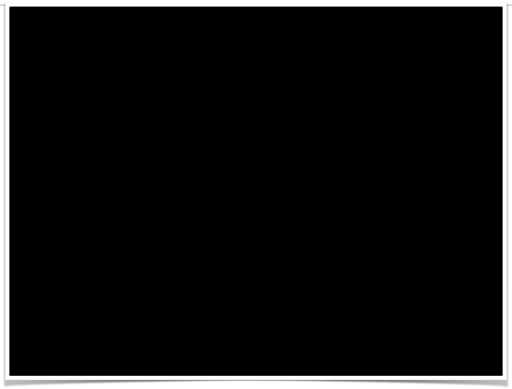


- A book may be able to reach where an adult cannot.

Please check the Dropbox for bibliotherapy resources and ideas.

IDENTIFY CRITICAL NEEDS AND SELECT READINGS THAT HAVE THIS AS THE THEME

There are many bibliotherapy lists online.



- **CBI is a collaborative effort between the therapist and the student**

  Student role - define goals, express concerns, learn & implement learning

  Therapist role - help student define goals, listen, teach, encourage.
- **Teaches the benefit of remaining calm or at least neutral when faced with difficult situations.** (If you are upset by your problems, you now have 2 problems:
- 1) the problem, and
- 2) your upsetness!

TRAINING IN CORE SKILLS

WHAT ARE "CORE SKILLS"?

- Based in learning theory
- Buffer against the development of mental health problems
- Assist in coping with stress or trauma

Self-calming exercises, thought-stopping, behavioral activation, and more. The Diagnostic Center Central offers a half-day or whole day workshop on CBI. For more information or to schedule this workshop: www.dcc-cde.ca.gov or

Implications

Assessing for trauma exposure,

making accurate diagnoses,

selecting efficacious interventions and

filing reimbursement claims.

facts

Many individuals with EBD in special education classrooms have other issues they are dealing with

- may have diminished intelligence
- may have language deficits
- may have untreated brain injury

Disproportionate representation of African American males

Fewer females

quandary

One student with PTSD may be distrustful, experience violent nightmares and behave aggressively, while another with a PTSD diagnosis is more withdrawn and self-blaming, with internally directed negative emotionality.

Conversely, an educator could have two students who present similar behaviors; and yet, due to the nature of the traumatic event, one could be diagnosable and the other not.

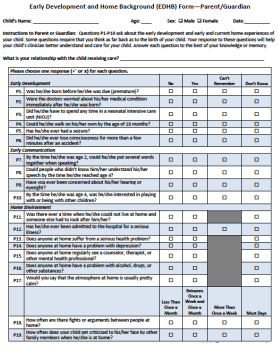
This may cause complications for schools in providing appropriate programming or in determining appropriate interventions.

In children, informal assessment of traumatic responses, although now facilitated by developmentally appropriate criteria in the DSM 5, may be particularly challenging.

This requires keen observation of behavior, interpersonal interactions, sleep patterns and play.

Cohen et al. (2010) suggested that child assessments must account for the onset of symptoms and changing patterns therein to avoid potential misdiagnoses.

Early Development and Home Background Form



Early Development and Home Background (EDHB) Form—Parent/Guardian

Child's Name: _____ Age: ___ Sex: ☐ Male ☐ Female Date: _____

Instructions to Parent or Guardian: Questions P1-P19 ask about the early development and early and current home experiences of your child. Some questions require that you think as far back as to the birth of your child. Your response to these questions will help your child's clinician better understand and care for your child. Answer each question to the best of your knowledge or memory.

What is your relationship with the child receiving care? _____

Please choose one response (✓ or x) for each question.

	Early Development	No	Yes	Can't Remember	Don't Know
P1.	Was he/she born before he/she was due (premature)?	☐	☐	☐	☐
P2.	Were the doctors worried about his/her medical condition immediately after he/she was born?	☐	☐	☐	☐
P3.	Did he/she have to spend any time in a neonatal intensive care unit (NICU)?	☐	☐	☐	☐
P4.	Could he/she walk on his/her own by the age of 18 months?	☐	☐	☐	☐
P5.	Has he/she ever had a seizure?	☐	☐	☐	☐
P6.	Did he/she ever lose consciousness for more than a few minutes after an accident?	☐	☐	☐	☐
	Early Communication				
P7.	By the time he/she was age 2, could he/she put several words together into sentences?	☐	☐	☐	☐
P8.	Could people usually understand him/her/her understood his/her speech by the time he/she reached age 4?	☐	☐	☐	☐
P9.	Have you ever been concerned about his/her hearing or eyesight?	☐	☐	☐	☐
P10.	By the time he/she was age 4, was he/she interested in playing with or being with other children?	☐	☐	☐	☐
	Home Environment				
P11.	Was there ever a time when he/she could not live at home and someone else had to look after him/her?	☐	☐		☐
P12.	Has he/she ever been admitted to the hospital for a serious illness?	☐	☐	☐	☐
P13.	Does anyone at home suffer from a serious health problem?	☐	☐		☐
P14.	Does anyone at home have a problem with depression?	☐	☐		☐
P15.	Does anyone at home regularly see a counselor, therapist, or other mental health professional?	☐	☐		☐
P16.	Does anyone at home have a problem with alcohol, drugs, or other substances?	☐	☐		☐
P17.	Would you say that the atmosphere at home is usually pretty calm?	☐	☐		☐
		Less Than Once a Month	Between Once a Week and Once a Month	More Than Once a Week	Must Days
P18.	How often are there fights or arguments between people at home?	☐	☐	☐	☐
P19.	How often does your child get criticized to his/her face by other family members when he/she is at home?	☐	☐	☐	☐

in Dropbox for this workshop or available on: https://www.psychiatry.org/psychiatrists/practice/dsm/dsm-5/online-assessment-measures

IN THE NEWS

www.inthenews.com AUTISM FORUM NEWSPAPER - Since ???

Numbers Rising!

IN THE NEWS

www.inthenews.com AUTISM FORUM NEWSPAPER - Since ???

9-1-1!

IN THE NEWS

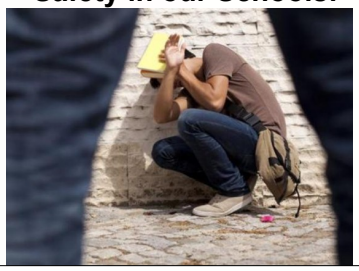
www.inthenews.com AUTISM FORUM NEWSPAPER - Since ???

Money, Money, Money!

IN THE NEWS

www.inthenews.com AUTISM FORUM NEWSPAPER - Since ???

Safety in our Schools!



case study

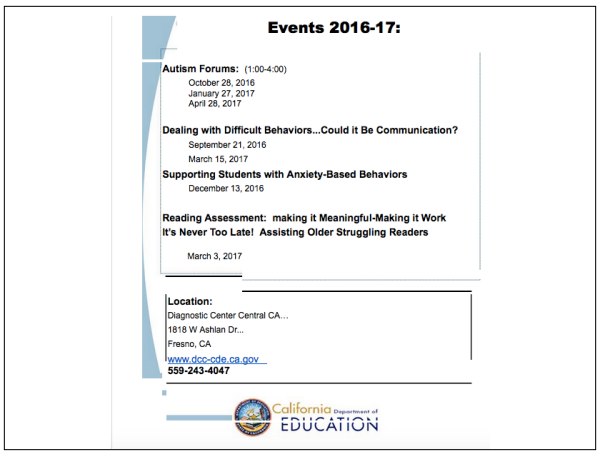
age 7

FSIQ = 86

Non-verbal = 108

Mother incarcerated for a period of time (grandmother is caregiver). characteristics: irritable, picky eater, delayed language,

Prenatal Cocaine Exposure (PCE)



Dropbox Resources

https://www.dropbox.com/sh/887e6x22rqd9jfj/AABQWfB88Dbxvvs1r2iSitipa?dl=0

if you hit the link (control+command+click) - it should take you to the dropbox.

aaspen@dcc-cde.ca.gov